STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155596	A. BUILDING 00 B. WING	08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND SKILLED NURSING AND REHABILITATION	500 N WILLIAMS ST ANGOLA, IN 46703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint # IN00111631. Complaint # IN00111631 Substantiated. Federal/state deficiencies related to the allegation are cited at F223. Survey dates: July 23, 24, 25, 26, 27, 31 and August 1, 2012 Facility number: 000474 Provider number: 155596 AIM number: 100290510 Survey team: Honey Kuhn, RN, TC Carol Miller, RN Deb Kammeyer, RN Shelly Vice, RN (July 23-26, 2012) Census bed type: SNF: 18 SNF/NF: 56 Total: 73 Census payor type: Medicare: 18 Medicaid: 41 Other: 14 Total: 73	F0000	This Plan of Correction is the center's credible allegation of compliance.Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts al-leged or conclusions set forth in thestatement of deficienceis. The plan of correction is prepared and/or executed solely because it is required by theprovisions of federal and state law.This facility respectfully requests that with the submission of additionalAttachments that our plan receive aDesk Review□□□□□	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 8/7/12 Cathy Emswiller RN			

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F0156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on record review and interview, the facility failed to ensure 3 of 3 residents reviewed for discharge from medicare services received the estimated costs of continued medicare skilled services. (Resident # 80, #78, and #69) Findings include: On 7/24/12 a Notice of Medicare Non-Coverage was received for residents #80 and #69 from the Administrator. On 7/25/12 at 1:15 P.M. a Notice of Medicare Non-Coverage was received for resident #78 from the Administrator. The Notice indicated 3 of 3 residents did not receive a list of estimated costs of continued Medicare Skilled Services, which included the room cost. According to the Department of	F0156	It is the intent of this facility to inform residents that are coming off of Med- care services of the estimated costs of continued medicare skilled services. F-156 On 8-14-12 the policy and procedure 8-31-12 for Notice of Medicare Non Coverage was reviewed and revised to include the notice of estimated costs. See Attachment A. This estimate will be given along with the Notice of Non Coverage effective 8-15-12. The Business Office Manager will re- view each Notice of Non Coverage to make sure the estimated costs	08/31/2012

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	Health Services Centers for Medicare & Medicaid Services: page 8, Notice to include: the additional items services, the reasons Medicare may not pay, and the estimated costs. On 7/25/12 at 1:15 P.M., the current Policy and Procedure titled Expedited Determination received from the Administrator, was reviewed and did not include the estimated costs notice. The Administrator indicated in an Interview on 8/1/12 at 8:20 A.M., the Policy did not require an estimated cost of continued Medicare Skilled Services at the time of Non-Coverage Notice. She stated, "A list of costs are with the admission information". The Administrator indicated a Schedule of Charges form was given at admission with the estimated cost of the room noted on that form. The costs were not discussed when the Non-Coverage Notice was given. 3.1-4(f)(3)		have been given to the resident. An audit will be conducted by the Administrator or designee on a month- ly basis for the first three months. If noissues are found the audit will be conducted on a quarterly basis for three quarters. Results of the audits will be submitted to the Quality Assurance committee overseen by the Admin- istrator	

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F0223 SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interviews, the facility failed to ensure residents were free of an incident of verbal abuse for 1 of 1 and neglect for 1 of 1 residents in a sample of 3 residents reviewed for abuse. (Resident "C" and Resident "D") Findings include: On 07/23/12 at 11:00 a.m., the facility Administrator provided for review 3 incidents the facility had investigated for abuse. Review of Investigation #3 at that time, indicated an allegation of resident neglect and abuse which was reported to the facility by a family member of resident 'C' on 06/28/12 that occurred on 06/26/12. The Administrator immediately initiated an investigation. The incident was reported to ISDH (Indiana State Department of Health) as required. Review of the investigation indicated Resident "C" asked to go to the bathroom at approximately 9:30 p.m. CNA #6 was	F0223	It is the policy and procedure of this facility to keep residents free from abuse and neglect. F223 The facilities policies and procedures 8-31-12 were followed throughout the investigation of the incident. The Certified Nurse Aides in question both received educational action for their actions.. Staff were inserviced by 8-19-12 on the facility's abuse and neglect policy and procedure, resident/staff interaction and customer services by 8-19-12. See Attachment B. Increased monitoring on weekends through the Weekend Manager program and periodic unannounced visits by management staff on 2nd and 3rd shifts will be instituted on 8-20-12 See attachedment C The unannounced visits will occur on a weekly basis for eight weeks. If no issues are reported the visits will be completed at least one time per month for the next six months. Should any incidents be reported through these systems, they will be investigated and reported per the facility's	08/31/2012

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	alleged to tell Resident "C" she was going to bed and was offered a bedpan. Resident "D", the roommate of Resident "C", reportedly addressed the CNA that Resident "C" was to be toileted in the bathroom, not to use the bedpan. Resident "D" indicated being told by CNA #6 to mind her own business. Further review indicated CNA #6 was suspended during the investigation. Neither Resident "C" or Resident "D" were listed on the facility census during the survey. A review of the most recent MDS (Minimum Data Set: a tool to assess residents for care), dated 06/30/12, indicated Resident "C" was cognitively impaired and required extensive assist of 2 people for transfers and toileting. The most recent MDS, dated 06/19/12, indicated Resident "D" was cognitively intact. The Administrator provided interviews with Resident "D" and staff completed during the investigation but which were not addressed in the facility's report. CNA #6 was interviewed on 07/31/12 at 1:15 p.m. CNA #6 indicated she was usually scheduled to work the day shift. On the day of the allegation, 06/26/12, CNA #6 was called in to work on evenings, arriving at approximately 9:10 p.m. to cover for an employee who went		abuse/neglect policy. Results of the Weekend Manager Program and the unannounced visits will be reported monthly to the Quality Assurance Committee.The Quality Assurance Committee,responsible to the Administrator, willreassess quarterly for continued needfor increased oversight with a subse-quent plan developed and implementedas indicated. Minimum oversight is sixmonths.	

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	home due to family illness. CNA #6 indicated she went to get Resident "C" ready for bed and Resident "C" asked to go to the bathroom. CNA #6 indicated Resident "C" was hard to handle due to her physical state and other staff were busy. CNA #6 indicated due to Resident "C"'s small stature, CNA #6 felt it would be difficult and painful for Resident "C" to get on the commode in the bathroom and offered a bedpan instead. CNA #6 indicated Resident "D" then began yelling and complaining to CNA #6 in regards to Resident "C" needing to use the bathroom not the commode. CNA #6 indicated she told Resident "D" to "mind her own business". CNA #6 than assisted Resident "C" to the bathroom and returned her to bed. CNA #6 indicated she did not have the assist of another staff member. CNA #6 indicated she apologized to Resident "D" after the incident and again the following day when she returned to work. The Administrator was interviewed on 07/25/12 at 10:30 a.m. The Administrator indicated the investigation interviews indicated no staff were aware of the incident at the time of the occurrence and the facility shared the investigation with the family member who reported the incident.			

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	Review of the facility's policy, "ABUSE PREVENTION, INTERVENTION, INVESTIGATION AND CRIME REPORTING POLICY: 09/2012", provided by the Administrator on 07/23/12 at 11:00 a.m., indicated: "POLICY: It is policy that every resident has the right to be free from verbal, sexual, physical, and mental abuse; neglect, corporal punishment, and involuntary seclusion. Any form of mistreatment of residents, including but not limited to abuse, neglect,...is strictly prohibited." "DEFINITIONS: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish.... Neglect is failure to provide goods and services necessary to avoid physical harm, mental anguish, ... Verbal Abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability." This Federal tag relates to Complaint #IN00111631.			

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	3.1-27(a)(3) 3.1-27(b)			

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F0224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record reviews and interviews, the facility failed to identify alleged rough treatment and or verbal shortness to residents by staff as evidenced by 2 residents on the 300 Unit who voiced incidents of rough treatment and 2 residents on the 400 Unit who voiced incidents of verbal shortness in communication by staff. This deficient practice affected 4 residents in a sample of 40 residents reviewed for potential abuse. (Resident # 57, Resident #54, Resident #20 and Resident #90) **Findings include:** **1. Resident #57 was interviewed on 07/24/12 at 10:00 a.m. Resident #57 indicated staff had been rough with him during care. When queried further, Resident #57 indicated he could not specify who it was or when it occurred. Resident #57 indicated he was not afraid of direct care staff and had not reported the incident.**	F0224	It is the policy and procedure of this facility to prevent abuse and neglect of the residents. F224 All four incidents reported to the Ad- 8-31-12 ministrator by the surveyors on 7-31-12, were reported per facility policy and procedure to the State Department of Health, Adult Protective Services and the area Om- budsman, that same date. 0n 7-31-12, an investigation was be- gun. Social Services Director inter- viewed resident #57, who also has expressive aphasia. He expressed to her that he had tried to explain to the surveyor that “he” had given an em- ployee a hard time – not the other way around. He felt he had hurt her feelings and was “rough” on her. He indicated that he would see the administrator if he felt he was not treated right. Interview with resident #54 by Social Worker obtained a descrip- tion of a person that did not fit a description on any of the workers. Resident #54 explained that what she meant by rough was that this person just tells her what to do. “turn over on your side”. Her approach is different. Due to the fact	08/31/2012

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	The record of Resident #57 was reviewed on 07/25/12 at 9:30 a.m. Resident #57 was admitted to the facility on 05/28/10 with diagnoses including, but not limited, to CVA (Cerebral-Vascular Accident: stroke), anxiety, (R) hemiplegia (Right sided weakness/loss of movement), anemia, depression, seizure disorder, and HTN (hypertension: high blood pressure.) **The most recent Annual MDS (Minimum Data Set: a tool to assess a resident), dated 05/05/12, indicated Resident #57 was cognitive for interview.** **Review of a nurse's note indicated: "06/23/12 3:00 p.m. Res (resident) swearing at CNA (Certified Nurse Assistant) during his shower. Writer entered shower room et (and) spoke c (with) Res et calmed him down. Res apologized to staff for his outburst."** **LPN #9, who works on the 300 unit, was interviewed on 07/27/12 at 10:15 a.m. LPN #9 was unaware of any instances of mistreatment to Resident #57 and indicated the resident had verbal outbursts at times. LPN #9 demonstrated knowledge in regards to the**		that Resident #54 has a diagnosis of dementia, her room mate, Resident #21 was also interviewed. Resident #21 is alert and oriented x3. Resident #21 stated that she has never heard any one be unkind or rough with Res- ident #54. She stated “they have all been kind to her”. Resident # 21 went on to explain that the prior evening Resident #54 woke up at 12:30 am wanting to go horseback riding. Resident #21 stated that the aide that sat with Resident #54 was very kind and sat with her talking Resident #21 through that episode. Interview with Resident #90 was conducted by the Social Worker. That resident indicated that she could not remember speaking with surveyors. When asked if any staff had been short with her, she replied” I have no information that staff was ever short with me.” “I feel comfortable here, very much so, I can’t imagine that anyone would say I wasn’t. Interview with Resident #20 by the Social Worker resulted in Resident #20 stating that he could not think of a specific in- cident where staff was short with him. His focus was on hiring strong individuals so he would not need two people to toilet him. Staff were inserviced on abuse/ne- glect, interactions between staff and residents and customer service by 8-19-12. See Attachment B. Increased monitoring on week ends began	

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	facility's Abuse policy and procedure. LPN #9 indicated staff did not routinely screen residents to establish staff care for residents were perceived as rough in nature. **2. Resident #54 was interviewed on 07/24/12 at 9:00 a.m. Resident #54 was queried, "Have you ever been treated roughly by staff?" and indicated, "about** 1 in 20 times" When queried further, Resident #54 indicated she did not report the incidents to anyone, and "If I knew, in the morning when she comes in, treats me rough." Resident #54 indicated it was the same unknown female. The record of Resident #54 was reviewed on 07/27/12 at 10:00 a.m. Resident #54 was admitted to the facility 12/16/11 with diagnoses including, but no limited to, (L) (left) displaced femoral neck fracture and (L) hip arthroplasty, dementia,, (R) (right) hip fracture, and hypothyroidism (low thyroid). The most recent MDS (Minimum Data Set: a tool to assess a resident), dated 06/18/12, indicated Resident #54 was cognitive status as moderately impaired. CNA #5, who works on the 300 Unit,		8-18-12 through the Weekend Manager Program. See Attachment C. In addition there will be periodic unannounced visits by Management staff on 2nd and 3rd shifts effective the week of 8-20-12. Five (5) residents will be interviewed by a Business Leadership Team member on a weekly basis for six weeksusing the survey resident interview tool to screen for any rough handling or rudeness by the staff. Should there be any incidents reported through these systems, they will be investigated and reported per the facility's policy and procedure on Abuse/Neglect. If there are no patterns or trends aftersix weeks,interviews will deccrease to 10 residents per month for 4 months.A Resident Council Meeting was held on 8-6-12 to inform residents of the need to report any rough handling or rudeness and who to report it to. All monioting reports and residentinterviews will be reviewed weeklyby the Business Leadership Team. Results from the monitoring and resident interviews will be submittedto Quality Assurance Committee ona monthly basis for review.The Quality Assurance Committee, responsible to the Administrator, will reassess quarterly for continued oversightwith a subsequent plan developed and implemented as indicated. Minimumoversight is six months.	

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	155596	A. BUILDING 00 B. WING	08/01/2012

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	was interviewed on 07/31/12 at 3:00 p.m. CNA #5 was unaware of any instances of rough treatment by staff towards Resident #54. CNA #5 was knowledgeable in regards to the facility's Abuse policy and procedure. The CNA indicated being unaware of screening residents in regards to rough treatment by staff. **The Administrator, DNS (Director Nursing Services), and Regional Nurse Consultant were interviewed on 07/31/12 at 2:30 p.m. The Administrator indicated no reported incidents for Resident #57 and Resident #54.** 3. The clinical record of Resident #90 was reviewed on 7/27/12 at 10:45 a.m. The record indicated Resident #90's diagnoses included, but were not limited to, pneumonia, myocardial infarction (heart attack), and hypertension. Resident #90's 30 day Minimum Data Set Assessment (a tool to assess residents for care) dated 6/18/12 indicated the resident's cognitive status was a 15/15: cognitively intact. Resident #90 was interviewed on 7/24/12 at 9:21 a.m. in regard to staff being rude and the resident indicated yes staff had been rude to the resident. Resident #90			

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	indicated he had not reported any incidents to staff. The Administrator was interviewed on 7/31/12 at in regard to resident #90's statement the staff had been rude to the resident and indicated she had no knowledge Resident #90 had been treated rude by the staff. CNA #15 was interviewed on 8/1/12 at 10:45 a.m. in regard to staff had been rude to Resident #90 and CNA #15 indicated the resident had never voiced a concern in regard to the staff had been rude to the resident. 4. The clinical record of Resident #20 was reviewed on 7/26/12 at 1:00 p.m. The record indicated Resident #20's diagnoses included, but were not limited to, general muscle weakness, anxiety disorder, bipolar, and obsessive compulsive disorder. The quarterly Minimum Data Set Assessment dated 5/21/12 indicated the resident's cognition was 14/15: cognitively intact. Resident #20 was interviewed on 7/30/12 at 12:03 p.m. and indicated at times staff, not the nurses, is "snappy" at the resident. The resident would not indicate who the staff were and when this incident had			

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	occurred. The Administrator was interviewed on 7/31/12 at in regard to Resident 20's statement the staff were "snappy " at the resident and indicated she was unaware of the staff being "snappy" with the resident. CNA #15 was interviewed on 8/1/12 at 10:40 a.m. in regard to staff being "snappy" with the resident and CNA #15 indicated the resident had never voiced a concern in regard to the staff not treating him well. CNA #15 indicated Resident #20 is slow to warm up to staff. **Review of the facility's policy, "ABUSE PREVENTION, INTERVENTION, INVESTIGATION & CRIME REPORTING POLICY: 9/2011), provided by the Administrator on 07/23/12 at 11:00 a.m., indicated:** **"POLICY: It is policy that every resident has the right to be free from verbal, sexual, physical, and mental abuse; neglect, corporal punishment, and involuntary seclusion.** **Any form of mistreatment of residents, including but not limited to abuse, neglect...is strictly**			

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	prohibited." **"DEFINITIONS:...Neglect is failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."** **"PROCEDURES:...Prevention: The facility shall identify, analyze, and assess the following situations to minimize the likelihood of abuse, neglect, ...:** **Regular staff monitoring to determine whether inappropriate behaviors are occurring, such as use of derogatory language, rough handling of residents, ..."** 3.1-28(a)			

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F0226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interviews, the facility failed to implement their Abuse Policy and Procedure in regards to identifying rough treatment for 2 residents and verbal shortness in communication by staff for 2 residents in a sample of 40 residents interviewed for abuse. (Resident # 90, Resident #20, Resident #54 and Resident 57). Findings include: **1. Resident #57 was interviewed on 07/24/12 at 10:00 a.m. Resident #57 indicated staff had been rough with him during care. When queried further, Resident #57 indicated he could not specify who it was or when it occurred. Resident #57 indicated he was not afraid of direct care staff and had not reported the incident.** **The record of Resident #57 was reviewed on 07/25/12 at 9:30 a.m. Resident #57 was admitted to the**	F0226	It is the policy and procedure of this facility to prevent abuse and neglect of the residents. F226 All four incidents reported to the Ad- 8-31-12 ministrator by the surveyors on 7-31-12, were reported per facility policy and procedure to the State Department of Health, Adult Pro- tective Services and the area Om- budsman, that same date. 0n 7-31-12, an investigation was be- gun. Social Services Director inter- viewed resident #57, who also has expressive aphasia. He expressed to her that he had tried to explain to the surveyor that “he” had given an em- ployee a hard time – not the other way around. He felt he had hurt her feelings and was “rough” on her. He indicated that he would see the administrator if he felt he was not treated right. Interview with resident #54 by Social Worker obtained a descrip- tion of a person that did not fit a description on any of the workers. Resident #54 explained that what she meant by rough was that this person just tells her what to do. “turn over on your side”. Her ap- proach is different. Due to the fact that Resident #54 has a diagnosis	08/31/2012

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	facility on 05/28/10 with diagnoses including, but not limited, to CVA (Cerebral-Vascular Accident: stroke), anxiety, (R) hemiplegia (Right sided weakness/loss of movement), anemia, depression, seizure disorder, and HTN (hypertension: high blood pressure.) **The most recent Annual MDS (Minimum Data Set: a tool to assess a resident), dated 05/05/12, indicated Resident #57 was cognitive for interview.** **Review of a nurse's note indicated: "06/23/12 3:00 p.m. Res (resident) swearing at CNA (Certified Nurse Assistant) during his shower. Writer entered shower room et (and) spoke c (with) Res et calmed him down. Res apologized to staff for his outburst."** **LPN #9, who works on the 300 unit, was interviewed on 07/27/12 at 10:15 a.m. LPN #9 was unaware of any instances of mistreatment to Resident #57 and indicated the resident had verbal outbursts at times. LPN #9 demonstrated knowledge in regards to the facility's Abuse policy and procedure. LPN #9 indicated staff did not routinely screen residents to establish staff care for residents**		of dementia, her room mate, Resident #21 was also interviewed. Resident #21 is alert and oriented x3. Resident #21 stated that she has never heard any one be unkind or rough with Res- ident #54. She stated “they have all been kind to her”. Resident # 21 went on to explain that the prior evening Resident #54 woke up at 12:30 am wanting to go horseback riding. Resident #21 stated that the aide that sat with Resident #54 was very kind and sat with her talking Resident #21 through that episode. Interview with Resident #90 was conducted by the Social Worker. That resident indicated that she could not remember speaking with surveyors. When asked if any staff had been short with her, she replied” I have no information that staff was ever short with me.” “I feel comfortable here, very much so, I can’t imagine that anyone would say I wasn’t. Interview with Resident #20 by the Social Worker resulted in Resident #20 stating that he could not think of a specific in- cident where staff was short with him. His focus was on hiring strong individuals so he would not need two people to toilet him. Staff were inserviced on abuse/ne- glect, interactions between staff and residents and customer service by 8-19-12. See Attachment B. Increased monitoring on week ends began 8-18-12 through the Weekend	

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	were perceived as rough in nature. **2. Resident #54 was interviewed on 07/24/12 at 9:00 a.m. Resident #54 was queried, "Have you ever been treated roughly by staff?" and indicated, "about** 1 in 20 times" When queried further, Resident #54 indicated she did not report the incidents to anyone, and "If I knew, in the morning when she comes in, treats me rough." Resident #54 indicated it was the same unknown female. The record of Resident #54 was reviewed on 07/27/12 at 10:00 a.m. Resident #54 was admitted to the facility 12/16/11 with diagnoses including, but no limited to, (L) (left) displaced femoral neck fracture and (L) hip arthroplasty, dementia,, (R) (right) hip fracture, and hypothyroidism (low thyroid). The most recent MDS (Minimum Data Set: a tool to assess a resident), dated 06/18/12, indicated Resident #54 was cognitive status as moderately impaired. CNA #5, who works on the 300 Unit, was interviewed on 07/31/12 at 3:00 p.m. CNA #5 was unaware of any instances of rough treatment by staff towards Resident #54. CNA #5 was		Manager Program. See Attachment C. In addition there will be periodic unannounced visits by Management staff on 2nd and 3rd shifts effective the week of 8-20-12. Five (5) residents will be interviewed by a Business Leadership Team mem-ber on a weekly basis for six weeksusing the survey resident interview tool to screen for any rough handling or rudeness by the staff. Should there be any incidents reported through these systems, they will be investigated and reported per the facility's policy and procedure on Abuse/Neglect. If there are no patterns or trends aftersix weeks,interviews will decrease to 10 residents per month for 4 months.A Resident Council Meeting was held on 8-6-12 to inform residents of the need to report any rough handling or rudeness and who to report it to. All monioting reports and residentinterviews will be reviewed weeklyby the Business Leadership Team. Results from the monitoring and resident interviews will be submittedto Quality Assurance Committee ona monthly basis for review.The Quality Assurance Committee, responsible to the Administrator, will reassess quarterly for continued oversightwith a subsequent plan developed and implemented as indicated. Minimumoversight is six months.	

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	knowledgeable in regards to the facility's Abuse policy and procedure. The CNA indicated being unaware of screening residents in regards to rough treatment by staff. **The Administrator, DNS (Director Nursing Services), and Regional Nurse Consultant were interviewed on 07/31/12 at 2:30 p.m. The Administrator indicated no reported incidents for Resident #57 and Resident #54. Resident #20. The Administrator indicated the facility had recently used the same survey tool as used during the ISDH (Indiana State Department of Health) survey to query residents in regards to abuse.** 3. The clinical record of Resident #90 was reviewed on 7/27/12 at 10:45 a.m. The record indicated Resident #90's diagnoses included, but were not limited to, pneumonia, myocardial infarction (heart attack), and hypertension. Resident #90's 30 day Minimum Data Set Assessment(a tool to assess residents for care) dated 6/18/12 indicated the resident's cognitive status was a 15/15: cognitive intact. Resident #90 was interviewed on 7/24/12			

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	at 9:21 a.m. in regard to staff being rude and the resident indicated yes staff had been rude to the resident. Resident #90 indicated he had not reported any incidents to staff. The Administrator was interviewed on 7/31/12 at in regard to resident #90's statement the staff had been rude to the resident and indicated she had no knowledge Resident #90 had been treated rude by the staff. CNA #15 was interviewed on 8/1/12 at 10:45 a.m. in regard to staff had been rude to Resident #90 and CNA #15 indicated the resident had never voiced a concern in regard to the staff had been rude to the resident. 4. The clinical record of Resident #20 was reviewed on 7/26/12 at 1:00 p.m. The record indicated Resident #20's diagnoses included, but were not limited to, general muscle weakness, anxiety disorder, bipolar, and obsessive compulsive disorder. The quarterly Minimum Data Set Assessment (a tool to assess residents care) dated 5/21/12 indicated the resident's cognition was 14/15: cognitive intact. Resident #20 was interviewed on 7/30/12			

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	at 12:03 p.m. and indicated at times staff, not the nurses, is "snappy" at the resident. The resident would not indicate who the staff were and when this incident had occurred. The Administrator was interviewed on 7/31/12 at in regard to Resident 20's statement the staff were "snappy " at the resident and indicated she was unaware of the staff being "snappy" with the resident. CNA #15 was interviewed on 8/1/12 at 10:40 a.m. in regard to staff being "snappy" with the resident and CNA #15 indicated the resident had never voiced a concern in regard to the staff not treating him well. CNA #15 indicated Resident #20 is slow to warm up to staff. **Review of the facility's policy, "ABUSE PREVENTION, INTERVENTION, INVESTIGATION & CRIME REPORTING POLICY: 9/2011), provided by the Administrator on 07/23/12 at 11:00 a.m., indicated:** **"POLICY: It is policy that every resident has the right to be free from verbal, sexual, physical, and mental abuse; neglect, corporal punishment, and involuntary seclusion.**			

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	Any form of mistreatment of residents, including but not limited to abuse, neglect...is strictly prohibited." **"DEFINITIONS:...Neglect is failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."** **"PROCEDURES:...Prevention: The facility shall identify, analyze, and assess the following situations to minimize the likelihood of abuse, neglect, ...:** **Regular staff monitoring to determine whether inappropriate behaviors are occurring, such as use of derogatory language, rough handling of residents, ..."** 3.1-28(a)			

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F0242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.			
	Based on record review and interviews, the facility failed to honor choices related to the resident's time to rise in the morning not being honored for 1 resident interviewed for choices in a sample of 40. (Resident # 54). Findings include: **Resident #54 was interviewed on 07/24/12 at 10:00 a.m.** Res #54 indicated she cannot chose when to get up and would prefer to get up later. Res. #54 indicated she has no choice in the matter. Resident #54 was admitted to the facility 12/16/11 with diagnoses including, but no limited to, (L) (left) displaced femoral neck fracture and (L) (left) hip arthroplasty, dementia, (R)(right) hip fracture, and hypothyroidism (low thyroid levels). Review of a form, titled, "Customary	F0242	It is the policy of the this facility to honor resident choices. F242 Resident #54 was interviewed by 8-31-12 Social Services on 7-31-12 for her choices concerning her ADL's. All choices were entered into her care plan and on her ADL sheets. The remaining residents were interviewed using the resident interview tool concerning resident choices. See Attachment E. Any choices found not to be care planned or on ADL sheets were corrected by 8-19-12. Staff were inserviced about honoring resident choices by 8- 19-12. See Attachment F 5 residents per week for 6 weeks will be queried by the Business Leadership Team as to whether their choices are being honored. If there are no patterns or trends, interviews will decrease to 10 residents per month for 4 months. All results of the interviews will be submitted weekly to the BusinessLeadership Team for review. The Business Leadership Team will submitted the results of the interviews tothe Quality	08/31/2012

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	Routine Activity Care Plan", dated 06/2012, indicated Resident #54 liked to go to bed at 7:00 p.m. Areas indicating "get out of bed at:" and "Take a nap at:" were blank. Resident #54 was observed on 07/27/12 at 7:30 a.m. in the MDR (Main Dining Room) dressed and seated in her wheelchair eating her breakfast. Resident #54 was observed to be napping after breakfast on 07/23/12 at 9:30 a.m., 07/24/12 at 9:00 a.m., 07/25/12 at 10:00 a.m., 07/26/12 at 9:00 a.m., and 07/31/12 at 9:30 a.m. Resident #54 was awakened for a scheduled interview on 07/24/12 at 9:00 a.m. and indicated she was tired. CNA #8 was interviewed on 08/01/12 at 11:00 a.m. CNA #8 indicated taking care of Resident #54 frequently and no knowledge of the resident wanting to sleep later. CNA # 8 indicated the night shift gets Resident #54 up and dressed before the day shift arrives. CNA #8 indicated the resident sleeps between meals and tires easily. **3.1-3(u)(1)**		Assurance Committee on a monthly basis. The Quality AssuranceCommittee, responsible to the Administratorwill review monthly and reassess quarterly forthe continued need for increased oversight with a subsequent plan developed and imple-mented as indicated. Minimum oversight is6 months.	

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop a care plan in regards to the instability of a resident's right shoulder for 1 resident reviewed for care plans in a sample of 22 residents reviewed for care plans. (Resident #48) Finding include: The clinical record of resident # 48 was reviewed on 7/27/12 at 9:00 a.m. The current care plans for resident # 48 did not contain any care plan problem or approaches for the	F0279	It is the policy of this facility that Care Plans are established to meetthe resident needs. F279Resident #48's care plan was revised 8-31-12to include the right shoulder pain andchronic dislocation on 8-1-12.See Attachment GNursing staff reviewed the resident roster by 8-19-12 for any other resid-ents who may have a simular chronic dislocation issue, care plans were reviewed and revised if needed.The Interdisciplinary Team was inservicedon updating Care Plans on 8-24-12.Care Plans will be reviewed/revised with new	08/31/2012

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	resident's right shoulder pain, swelling, redness, or dislocation. The resident's diagnoses included, but were not limited to, Achalasia, gastric ulcer, pacemaker, hyperlipidemia, hypothyroid, anxiety, Left retina detachment, Benzodiazapine dependence/iatrogenic, mood disorder, and mixed incontinence. A Change in Condition Form for Resident #48 completed 4/1/12 indicated a CNA was called into the resident's room by the daughter to have the CNA look at her mother's right arm. The CNA had the nurse come in and assess the area. It was documented Resident #48 had an area of swelling under the right arm. The Assessment indicated no pain or redness noted and the physician was notified. [name of] Nurse Practitioner [N.P.] assessed the resident on 4/2/12 . The resident received an antibiotic for cellulitis of the right arm. The Nurse's assessment on 4/9/12 indicated the resident complained of pain in the right shoulder and was unable to raise arm for a week. The Nurse contacted the resident's physician and an x-ray was obtained at facility and revealed no fracture or dislocation with a conclusion of		doctors orders, Significant Change, Quarterly, and Annual MDS.Any Change of Condition will have aCare Plan instituted on the SBAR and reviewed by the Interdisciplinary Team during Walking Rounds with the resident.The MDS Coordinator will be respon-sible to audit Care Plans with each MDS review and report any updates needed to the Director of Nursing. Any patterns or trends will be reported by the MDS Coordinator on a weekly basisto the Business Leadership Team. The BusinessLeadership Team will report the results on a monthly basis to the Quality Assurance Committee.The Quality Assurance Committee, responsible to the Administrator will reassess quarterly for continuedneed for increased oversight with a subsequent plandeveloped and implemented as indicated. Minimumoversight is six month.	

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	normal humerus. The physician ordered Ultram (a narcotic pain medication) on 4/10/12 to decrease the pain. The Resident was to have an appointment made to see an orthopaedic physician. The appointment was made for 4/25/12. A Change in Condition Form completed 4/15/12 at 5:00 P.M., indicated a large mass in the right axilla area that had erythemia, warmth and was tender to touch. The Resident indicated in report that the onset was that afternoon. The physician was notified by fax of the change at 7:00 P.M. on Sunday 4/15/12. The resident was seen on 4/16/12 by the N.P. and sent to the ER for Right Axilla...red, warm and tender. The resident was assessed by the ER physician at [name of] hospital and an x-ray obtained that indicated an anterior humeral head dislocation (shoulder dislocation). She was referred to an orthopedic physician and received a closed reduction procedure to correct the dislocation under sedation at [name of hospital documented]. On 7/31/12 at 11:30 A.M., received the Policy titled 'Managing Change of Condition', and reviewed at that time. The document indicated Care Plans should be reviewed, revised, and			

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	resolved per facility practice. On 7/31/12 at 11:40 A.M. interview with DSN indicated the resident had the shoulder problem previously around the first of the month. The DNS was unable to locate a Care Plan regarding the right shoulder problem. . Interview with CNA #10 from the 200 hall on 7-31-12 at 2:15 P.M. indicated the CNA worksheet did not note a shoulder problem with Resident #48. The current MDS [minimum data set] assessment indicated the resident's status was: Functional Limitation in Range of Motion: upper extremity - impairment on both sides. During interview on 4/27/12 at 9:55 am, with a family member of resident # 48 indicated they were aware of Resident #48 falls and indicated resident # 48 occasionally fell at home prior to coming to the facility. The family spoke about the right shoulder situation. The family member noticed a painless lump under the resident's right arm and called the nurse to look at it. An x-ray was obtained for two views of the right shoulder at the facility which indicated the resident had no fracture			

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	or dislocation. Approximately two weeks later her whole arm was swollen and red. The Resident was sent to [name of hospital stated] where it was discovered thru x-ray the resident had a dislocated right shoulder. The resident was transferred to [name of town] to see an orthopedic doctor to have it put back into place. The Family member indicated the resident refused to allow the staff to help her and her falls were because she was reaching for things out of her reach. The resident can't see out of left eye and was not sure if that is why she falls but the family member believed the staff was doing everything they could to keep the resident from falling. The family member Stated, "mom wants her own way." The Family member voiced she had never had any concerns regarding the staff and if the resident reported to family member any problems family member would be in the Administration office immediately. The resident had never mentioned to the family member that staff has been rough with her. The resident's current care plans did not addressed the decreased stability or chronic right shoulder rotator cuff tear. The orthopedic physician indicated in his follow up report dated			

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	4/27/12, Resident #48 had arthritis and chronic rotator cuff tear that could lead to further instability episodes. The flow sheets for the CNA's received from the DNS on 7-31-12 at 2:45 P.M. indicated no preventative care when positioning or moving Resident #48 with an unstable right shoulder. 3.1-35(a)			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to transcribe a physician's order in regards to the discontinuation of a medication for 1 of 1 residents reviewed in a sample of 10. Resident #48 Findings include: The clinical record of Resident #48 was reviewed on 7/26/12 at 3:40 P.M. The physician orders indicated the facility physician wrote an order to discontinued the drug Tramadol due to non-use by the resident. The order was dated 7/11/12 at 11:00 A.M., and was received by LPN #14. The resident's diagnoses included, but were not limited to, achalasia,	F0514	It is the policy of this facility that residents will have complete and accurate medical records. F514 Resident #48's order was corrected 8-31-12 during the survey on 7-26-12 Doctors telephone orders will be checked off shift to shift and signed off by each nurse that the medica- tions and treatments have been ver- ified for accuracy. Nursing staff were inserviced by 8-19-12. See Attachment H Telephone orders will be audited by the DON/ADON/Staff Development Director, two(2)times weekly for compliance for three months. If there are no trends or pattern the audits will	08/31/2012

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	gastric ulcer, pacemaker, diabetes type ll, chronic obstructive pulmonary disease (COPD), hyperlipidemia, hypothyroid, anxiety, left retina detachment, benzodiazapine dependence/iatrogenic, mood disorder, and mixed incontinence. A review of the Medication Administration Record (MAR) on 7/26/12 continued to list the Tramadol as an available drug the nurse could have administered if the resident had pain. The Tramadol had not been discontinued by LPN #14. Interview on 7-26-12 at 3:50 P.M. with DNS, indicated the Medication was removed from the medicine cart and could not be given. The Drug Disposition log indicated the remaining Tramadol was destroyed on 7-13-12 indicating the discontinued drug could have been given 5 days after the order was written to discontinue the medication. No doses were given to the resident during the 5 days. The DNS wrote the discontinuation of the drug on the MAR the 26th of July 2012. 3.1-50(a)(2)		be decreased to 2x's per month for the next three months. The results of the audits will be submitted by the DON to the QA Committee on a monthly basis. The QA Committee responsible to the Administrator will reassess quarterly for continued need for increased oversight with a subsequent plan developed and implemented as indicated. Minimum oversight is six months	

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